PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on Wednesday, February 13, 2008, 9:00 a.m., at the Department of Public Health, 250 Washington St., Boston, Massachusetts in the Henry I. Bowditch Public Health Council Room. Members present were: Chair John Auerbach, Commissioner, Department of Public Health, Mr. Harold Cox, Dr. Michèle David, Dr. Muriel Gillick, Ms. Lucilia Prates Ramos, Mr. José Rafael Rivera, Dr. Meredith Rosenthal, Dr. Michael Wong (arrived at approximately 9:30 a.m.) and Dr. Barry S. Zuckerman. Absent Members were: Ms. Caulton-Harris, Dr. John Cunningham, Mr. Paul J. Lanzikos, Mr. Albert Sherman, and Dr. Alan C. Woodward. Also in attendance was Attorney Donna Levin, General Counsel, Department of Public Health.

Chairperson Auerbach announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance and further said that the agenda order would change. The Members introduced themselves to the audience.

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF NOVEMBER 14, 2007:

The record of the Public Health Council Meeting of November 14, 2007 was presented to the Public Health Council for approval. Copies of the minutes were distributed to the Council prior to the meeting for review. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the **Record of November 14, 2007** as presented.

PROPOSED REGULATION: INFORMATIONAL BRIEFING ON PROPOSED REVISIONS TO 105 CMR 164.000 ET SEQ.: LICENSURE OF SUBSTANCE ABUSE TREATMENT PROGRAMS; THE RESCISSION OF EXISTING CHAPTERS RELATING TO THE LICENSURE OF SUBSTANCE ABUSE TREATMENT; AND, AMENDMENT OF 105 CMR 130.000 AND 105 CMR 140.000 (HOSPITAL AND CLINIC REGULATIONS), TO THE EXTENT THEY INCORPORATE THE SUBSTANCE ABUSE TREATMENT REGULATIONS BY REFERENCE:

Mr. Michael Botticelli, Director, Bureau of Substance Abuse Services, DPH made introductory remarks and gave an overview and spoke briefly about the history of the Substance Abuse program in DPH. He said in part, "…Our annual budget is eight hundred and twenty-five million dollars, comprised of state and federal appropriations…We license approximately 1600 addiction counselors in the Commonwealth, as well as 266 licensed treatment programs. Many of these programs have multiple sites. We license 500 discreet sites, and those programs are delivered by a 131 organizations in the Commonwealth."

Attorney Tracy Miller, Deputy General Counsel, made an Informational Briefing to the Council on the proposed revisions to 105 CMR 164.000. She noted in part and the memorandum to Council also states, "…The proposed revisions constitute a major revision of the licensing regulations. BSAS proposes to consolidate seven chapters of regulations and two guidelines into one chapter, 105 CMR 164.000. The proposed chapter is divided in two parts: the first part is applicable to all licensees and the second part consists of different levels of care, each applicable to its respective level of care. Concurrently, BSAS proposes to rescind the existing seven chapters of the regulations relating to licensing of substance abuse treatment programs. The Division of Health Care Quality also proposes to amend 105 CMR 130.365: Hospital Licensure and 105 CMR 140.801: Clinic Regulations to incorporate the revised Substance Abuse Treatment Licensing Regulations by reference."

Staff's memorandum further explains, "The substance abuse treatment licensing regulations were developed over a number of years according to service modality and were last revised in the mid-1990s. A patchwork of state and federal regulations continues to create challenges to regulation and enforcement in this highly complex field. The consolidated draft regulations are intended to streamline and replace the separate chapters and guidelines that resulted in redundancies and discrepancies. Current state regulations and guidelines include:

105 CMR 160.000	Acute Care Inpatient Substance Abuse Detoxification Treatment Services
105 CMR 161.000	Short Term Inpatient Treatment Centers
105 CMR 162.000	Licensure of Substance Abuse Outpatient Services
105 CMR 165.000	Halfway Houses for Alcoholics
105 CMR 166.000	Approval of Residential Alcohol Treatment Programs for Operating under the Influence Offenders
105 CMR 167.000	Methodology for Setting Fees for Driver Alcohol Education Programs and Treatment Programs
105 CMR 750.000	Licensing and Approval of Drug Treatment Programs
Guidelines	Transitional Support Services Standards
Guidelines	Family Substance Abuse Shelter

She said further, "Changes in federal regulations and treatment standards since the 1990s also drove the need to revise the Massachusetts regulations. Massachusetts' regulations should incorporate these standards including, for example:

- New Federal Opioid Treatment Regulations issued in 2001, which changed terminology, take-home dosing standards, and drug screening requirements.

- The American Society of Addiction Medicine's (ASAM) criteria for admission services, staffing, and organization of substance abuse treatment levels of care."

Staff's memorandum to the Council indicated, "Services addressing substance related disorders have changed. The integration of substance abuse and mental health services in response to clients with co-occurring disorders and the special needs of women with children and of adolescents have emerged as treatment concerns over the last decade and are not adequately addressed in current regulations."

Atty. Miller said further, "A work group undertook a thorough and iterative review process to draft these proposed regulations. It reviewed all exiting BSAS regulations and guidelines and compared them to other states' regulations and national standards to identify gaps, redundancies and out-dated standards. In addition, it reviewed the federal regulations to ensure compliance and it used the ASAM guidelines and patient placement criteria as a reference tool in defining levels of care. Representatives of BSAS and the Department's General Counsel's Office, as well as other MDPH programs and the Department of Mental Health scrutinized the regulations during this process and consulted with their counterparts in other state and federal substance abuse treatment programs. Last fall, the Department circulated the proposed amendments to advisory groups comprised of representative providers from each level of care and consumers. The work group met with the representatives of each level of care to hear their comments. These proposed regulations for public hearing represent changes incorporated after reviewing all comments from the advisory groups."

Staff's memorandum to the Council explains the new structure of the proposed regulations: "…Provisions in part one applies to all licensed programs. In part two, licensees need only refer to the level of care that applies to their programs(s).

Part One: 105 CMR 164.087 (generally referred to as "Part One" contains provisions applicable to all licensees, regardless of program model or level of care. These provisions include:

- Requirements for the licensing application, inspection, and enforcement;
- Basic organizational requirements, such as governance, finance, employee training and supervision; and,
- Basic substance abuse treatment components, which should be part of every program, such as admission, assessment, treatment plans, after-care and follow-up, client rights, client records, and confidentiality.

Part Two: 105 CMR 164.100 through 164.454 (generally referred to as "Part Two" is divided into separate sections governing different levels of care:

164.100	Acute Services	
	164.111	Acupuncture
	164.121	Outpatient Detoxification
	164.131	Inpatient Detoxification
164.200	Outpatient Services	
	164.211	First Offender Driver Alcohol Education
	164.221	Counseling
	164.231	Day Treatment
164.300	Opioid Treatment	
164.400	Residential Rehabilitation	
	164.420	Residential Rehabilitation for Adults
	164.430	Residential Rehabilitation for Adults with their Families
	164.440	Residential Rehabilitation for Adolescents
	164.450	Residential Rehabilitation for Operating Under the Influence Second Offender

New Provisions: Several new or substantially revised sections:

- Fees: Section 164.008 provides a new structure and process for submission of application fees.

- Determining Suitability: Section 164.010 clarifies the Department's scope and authority in determining the suitability of an applicant for a license or approval.

- Transfers of Ownership: Section 164.012(F) clarifies the Department's authority in considering license applications when ownership of a program or facility is transferred and establishes clear time frames for notice and submission of license applications.

- Governance: Section 164.030 clarifies duties, responsibilities and characteristics of governing bodies.

- Notices to the Bureau: Section 164.035 clarifies circumstances when notice to the Department is required.

- Marketing of Services: 164.036 is a new provision governing advertising of substance abuse services.

- Child Safety: Provisions previously included in Bureau guidelines are now in regulation in section 164.059.

- All Hazards and Emergency Planning & Procedures: Section 164.062 specifies requirements for planning and implementing responses to emergencies.

- Behavior Management: Section 164.078 requires written policy and procedures for managing disruptive behavior.

- Opioid Treatment: A separate section was created for Opioid Treatment (164.300, et seq.). This section includes new provisions governing drug screening, take-home doses, and emergency involuntary terminations.

- Transitional Support Services: These services are included in the Residential Rehabilitation level of care (Part Two, 164.400 et seq.). Limitations on referral source for these services were removed.

Language Changes: Several major changes in terminology are included:

- Substance abuse treatment "types", which were previously referred to as "modalities" are now called "levels of care". This change in terminology reflects the understanding of treatment models as a continuum in which some forms of treatment are more comprehensive or intensive than others, i.e. are different levels of care. The difference is based on the differing needs of individuals for substance abuse treatment.

- Narcotics treatment is now referred to as "Opioid Treatment" reflecting the change in federal terminology, applying a broader term.

- Staff position titles, formerly "Clinician 1", Clinician II" and Clinician III" are changed to "Senior Clinician", "Clinician" and "Counselor", respectively. This change seeks to reduce confusion created by the similarity in numbering systems between the previous titles and the Licensed Alcohol and Drug Counselor (105 CMR 168.000) numbering systems.

Levels of Care: Part Two: 105 CMR 164.101 through the 164.453 reflects a substantial reorganization to conform to current standards of care.

- Admission and program component provisions incorporate standards established by the American Society for Addiction Medicine.

- Each level of care has a separate section. Previously all varieties of outpatient services were mixed in one chapter (105 CMR 162.000), while varieties of residential services were each in separate chapters or guidelines.

- New sections reflect new levels of care: for example, residential services for adolescents and for families, not previously in regulations.

- Provisions governing narcotics treatment, formerly included with all other outpatient services, are in a separate section, entitled "Opioid Treatment", reflecting changes in federal regulations.

Note for the record, Council Member Michael Wong arrived at the meeting at this time, approximately 9:30 a.m., just as Ms. Jacobs began her presentation.

Ms. Hilary Jacobs, Licensing Manager, Bureau of Substance Abuse Services addressed the Council on Part II section of the proposed regulations. She said in part, "…The proposed regulations reflect current standards of care; one, by including the ASAM criteria, which we have already talked about. There also were changes to the acupuncture classification statutes that reflect current practices. Additionally what has changed is improved quality of care for special populations so that there are inpatient detoxification regulations that are specific for youth that did not exist previously. In fact, we didn't have youth specific detoxification facilities until last year….In terms of access, youth is this new population. We have also for some time been providing facilities for adults who can bring their families with them, which is a really important thing. We had only guidelines for these facilities so now they are incorporated into the regulations."

In terms of non-discrimination, Ms. Jacobs noted, "There is a change in these regulations that state that a program cannot deny admission based solely on the patient's use of a prescription medication. We have had programs who routinely bar admission of some clients because they may be on diazapines or opioid assisted medication like suboxone or methadone…What that does is, it opens up the continuum of care that we provide to a whole group of people who have had difficulty accessing care."

Ms. Jacobs noted further, "…In terms of improved care, youth counseling services must be separate from adult services. There has been a co-mingling of those services. It has been problematic. The proposed regulations specifically states that needs to happen."

In closing, Ms. Jacobs noted that a public hearing is scheduled for March 27, 2008 on the proposed revisions to the Substance Abuse Regulations and the other affected public health regulations. They expect to return to the Council in May or June for final promulgation and expect implementation of the regulations to happen about three months after final approval.

No Vote/Information Only

Discussion followed by the Council Members. Dr. Barry Zuckerman, Council Member, asked about the treatment of drug addiction with suboxone versus the old medications [methodone]. Ms. Jacobs replied that the Department has funded 18 OBOTS (Office Based Opioid Treatment) in community health centers. She said, "We have funded the OBOTs for a number of reasons. One is that Massachusetts has one of the highest rates

of opioid addiction in the country. We have long waiting lists of people with opioid addictions waiting to get into treatment. It is an appropriate treatment for a specific sub-population, particularly people who don't have habits that have been going on for that long, or have lower tolerance to the opiates, and what we are trying to do with these eighteen OBOTS is to create a standard of care across the Commonwealth….We have also funded tactical assistance to these OBOTS so that we can really create a standard of care that requires that the medication-assisted therapy is combined with behavioral interventions, which is not required in the federal regulations that allow the suboxone."

Discussion continued and the problematic barriers noted to physicians prescribing Opioid treatment and they were (1) federally mandated training for physicians who want to prescribe treatment [as a special certified substance abuse expert] (2) physicians don't have enough nurse case management assistants to appropriately administer and maintain clients; and (3) federal enrollment caps on the number of patients a physician can treat. Ms. Jacobs noted that the cap is 30 patients the first year and then 100 patients thereafter. Ms. Jacobs further noted that the reason that methadone remains the standard for pregnant women is because the FDA has not approved the use of suboxone for pregnant women, though there are studies and anecdotal evidence that show with suboxone you get less fetal stress syndrome. Council Member Zuckerman responded, "Too bad the FDA is the gold standard because it does not seem like it is the right standard."

Council Member José Rafael Rivera asked, "Are there regulations to help residential programs provide services to individuals who are undergoing reorientation therapies?" Mr. Michael Botticelli, Director, Bureau of Substance Abuse Services replied, "There are not but I would welcome a conversation with you in terms of either policies or guidelines or best practice issues." Mr. Rivera asked further, "Under assessment in the proposed regulations, there was a requirement to do HIV/AIDS risk assessment. I noticed that Hepatitis C was not included. Any reason?" Ms. Jacobs replied that it was an oversight and they thought it was corrected. It will be in the regulations."

Dr. Michele David inquired about a statement in the proposed regulations that states a client is prohibited from being discharged to a shelter. Ms. Jacobs confirmed that the statement does prohibit that but the Department funds a number of case management and housing services for homeless people with substance abuse disorders. Ms. Jacobs said further, "I don't think it ever happened that someone is prohibited because the Department steps in and helps with the transition plan for that person."

Mr. Harold Cox, Public Health Council Member said in part, "…I am looking forward to the comments that you get from the public hearings because those will certainly indicate to us the kinds of things that the constituency says that this works or doesn't work…When you come back, if you could also expand the conversation because while this is incredibly important, about improving the quality of the care and the regulatory activities, I would also be interested in just a fuller conversation about what is actually available. I have the sense that we don't have enough services, and that there are real gaps in services, and I would be really interested in understanding what the services look like, and with particular emphasis on what is missing.'

Mr. Michael Botticelli, Director, Bureau of Substance Abuse Services replied, "We would be happy to do that. I think particularly over the past several years, that funding has increased with the Bureau. Our service continuum has changed dramatically. That doesn't necessarily mean that there is still not tremendous need for treatment or service gaps, but I do think it would be good to revisit what our continuum of care looks like at this point in time because it has changed dramatically over the past few years."

Dr. Michael Wong, Public Health Council Member stated, "…I have had one of those very unusual reverse translational moments, where normally we expect folks who are coming into the community health centers to continue to come into the academic medical centers, your large medical centers for extension of their health care services, one of the problems we have been experiencing in the hospital, in which I am employed is we are not one of those OBOTS and we don't have a lot of folks who are actually licensed in suboxone, although I am in the process of trying to undergo some of the training myself right now. We don't have the mental health and the counseling component that is actually integrated into the program, but we do at the community health center where I spend a half day a week. I am actually transitioning patients from my clinic at the BI Deaconess over to the DMC for suboxone therapy in situations like this. It has been a little bit of a reverse type of translation and I think it is a real life example of what Dean Cox was highlighting, that we really don't have a good idea of what kind of services exist, and are really on the ground in this State, that would be helpful to know."

Chair Auerbach said in part, "…It is clear that this will go a long way in terms of both modernizing and strengthening our ability to provide good services."

No Vote/Information Only

FINAL REGULATION: REQUEST FOR FINAL PROMULGATION OF PROPOSED AMENDMENTS TO 105 CMR 130.000 (HOSPITAL LICENSURE) REGARDING PREVENTION AND REPORTING OF HEALTHCARE-ASSOCIATED INFECTIONS – Part 1 Paul Dreyer (See part 2 later in the document):

Dr. Paul Dreyer, Director, Bureau of Health Care Safety and Quality, presented the final proposed amendments to 105 CMR 130.000 Hospital Licensure regarding prevention and reporting of healthcare associated infections. He said in part, "…What I wanted to do today was give some context for the recommendations about hospital-acquired infections because those recommendations come from the recommendations of the Quality and Cost Council. I wanted to give some context around those recommendations that you will be hearing later."

Dr. Dreyer continued, "This is the legislative mandate. This is from Health Care Reform, Mass. General Law Chapter 6A, Section 16L. It says the Council that is the Health Care Quality and Cost Council, shall develop and coordinate the implementation of health care quality improvement goals that are intended to lower or contain the growth in health care

costs while improving the quality of care, including reductions in racial and ethnic disparities. That is the legislation. The Council has developed specific goals for FY 2008. The general goal is to ensure patient safety and effectiveness of care, and these are the Council's three general goals for this fiscal year:

(1) To reduce Hospital-Associated Infections during FY'08 and this is a very ambitious goal, to eliminate Hospital-Associated Infections by 2012. We will be able to track our progress towards that goal over the next several years.

(2) The second goal of the Council is to eliminate serious reportable events, as defined by the National Quality Forum, to eliminate events that should never happen in hospitals, such as wrong surgery, wrong site, or wrong patient, and seek to improve overall patient safety and effectiveness of care.

(3) Goals A and B are specific to the work that we have been doing, and that you have heard about so far with respect to health care or hospital-associated infections. This is a more specific operational recommendation from the Council. DPH should be responsible for collecting Hospital-Associated Infection patient's race and ethnicity so that DPH can identify any racial or ethnic disparities. This is still a draft recommendation. The Council hasn't formally voted to accept this language but I think we are confident that it will accept this language or language very similar to it.

Dr. Dreyer stated, "With respect to Serious Reportable Events, the Council has several recommendations. DPH and the Board of Registration and Medicine's Patient Care Assessment Program should report to the Council by June 2008 on how they will work together to align their Serious Reportable Event reporting requirements and oversight activities to the maximum extent possible, given the differences in their missions and statutory mandates; and, more specifically, DPH should continue to collect data on serious adverse events. The required report format should include the patient race and ethnicity so that DPH can identify racial and ethnic disparities."

Dr. Dreyer continued, "We have been collecting data on Hospital Serious Incidents for many years. Our database began in 1995. Hospitals have been reporting events to us in categories that we have identified. What has recently changed is with the mandate of the Cost and Quality Council is that we collect Serious Reportable Events as defined by the National Quality Forum. These are sometimes called Never Events but that term we should get away from. The Official term now is Serious Reportable Events. These are surgical events, and these mostly involve around some sort of misidentification. Either a wrong body part is operated on; a wrong patient is operated on. That is one series of events. There is another series of events involving retained objects, which happens more frequently than we would like to see. Often, it is a surgical sponge or a clamp, or a piece of a probe will break off and be left in a wound. Those are surgical events. There are product or device events, such as contaminated drugs or devices that fail. Those often involve FDA issues. There are patient protection events. These generally involve failures in the system of care. Medication errors are by far the most frequent of those

events. Hemolytic reactions to blood products which occur when there is transfusion errors or just in retyping, although there can be some unavoidable hemolytic reactions. There are labor issues, which also can involve misidentification."

Dr. Dreyer continued further, "Stage 3 and 4 pressure ulcers are on the list. If developed in the hospitals, they should not occur. There are environmental events, patients receiving electric shock. There are problems with medical gases. Burns happen more frequently than you might expect, often involving surgical procedures, laser procedures where oxygen is involved. If you think about it, a laser plus oxygen is a recipe for a fire. We have always received reports of operating fires, which often involve cautery and oxygen. There is a series of what are called criminal events: impersonation, abduction, sexual assault, physical assault, and wrong sperm or wrong egg matters, donations…"

"What we did", stated Dr. Dreyer, "We have been collecting events since 1996. In December, we asked hospitals, as of January 1st; to categorize the events that they were reporting against NQF criteria…I ran a quick report this morning and found that we have received 15 such reports to date, since January 1st. I think those were all falls with serious disability. I should mention that the last change NQF made to its list was to amend the definition of falls that needed to be reported. Prior to this recent change in the Fall of 2006, falls with death needed to be reported. NQF has modified that definition to include falls with serious disability which is going to result in a large expansion of the number of falls that get reported. This definition is consistent with what we have always required to be reported. So the falls that get reported will now be NQF. The reports we have received so far have been falls. Other events are much rarer. The wrong site surgeries, the retained objects are much rarer than the falls, and that is why folks in hospitals are reluctant to call them Never Events, they know they happen much too frequently to be considered Never Events."

In summary, Dr. Dreyer stated, "That is where we are now. The next steps, in line with the recommendations of the Health Care Quality and Cost Council are to modify the system to collect race and ethnicity data. We are trying to develop an on-line reporting system, to which both DPH and the Board of Registration in Medicine, which has its own reporting requirements, can report. We have the single on-line reporting system for both agencies and then our ultimate goal will be to produce on-line reports of NQF incidents by hospital with timelines to meet the goal….When you hear the next presentation, you will hear about the regulations that we are promulgating, which will address the other arm of the Council's recommendations around Hospital-Acquired Infections."

Chair Auerbach summarized in part, "…What we have attempted to do here, was to take what had been a historical listing, based on upon other purposes, of what we thought would be important events to report, and instead change it to what is the gold standard, and the gold standard in terms of reporting these types of events, is what was developed by the National Quality Forum…The second thing I would say is this is in line with the work that the Public Health Council has done around the importance of transparency of quality indicators, making them available to the public, and the idea here is, more information can be useful, both as an incentive for institutions to adopt better practices,

and in terms of the public being able to get a sense of which institutions are doing the best jobs, where is there some problems or concerns."

Chair Auerbach continued, "…The goal in the future will be posting this information on a web site together with the Hospital-Acquired Infection Information along with other information we have spoken about in the past like cardiac outcomes. The goal is to have a single accessible user-friendly site that a member of the public can get on, click a hospital, and see a range of different quality indicators, in a way that is useful and helpful to them to understand."

Chair Auerbach further noted that the Department will be working with the Cost and Quality Council to develop a public web site where one can access DPH information as well as information from other sources. This will eliminate unnecessary duplication and the Cost and Quality Council has the funding to create such a web site.

Chair Auerbach added, "The final thing I would say is that our objective, with regard to gathering this information around serious incidence, is to prevent them. The main goal is to prevent them, not to have more information about where they occur. We will be talking to our colleagues at the Coalition for the Prevention of Medical Errors with whom we contract to provide education, training, support and technical assistance to hospitals around Hospital-Acquired Infection Prevention. We will be talking to the Coalition about also working on these issues in our next year's contract, so that we can be proactive in terms of helping hospitals think about model best practices to try to reduce these occurrences." Commissioner Auerbach noted that the Department is working on the issue of hiring inspectors who can follow-up and investigate when a bad event occurs at a hospital to understand what caused it and to work with the hospital to prevent a future occurrence.

A brief discussion followed whereby Dr. Rosenthal and Ms. Prates Ramos inquired further about how the information is being disseminated to the public. Commissioner Auerbach replied, "I think we will pay attention to the issue of how to make this kind of information available in multiple venues and in multiple languages so that people do have the ability to take advantage of it."

PRESENTATION: "HIGHLIGHTS FROM MASSACHUSETTS BIRTHS, 2006" By Dr. James West, Chief Demographer, Division of Research and Epidemiology, Bureau of Health Information, Statistics, Research and Evaluation, DPH:

Dr. James West proceeded, "I am pleased to present Highlights from the Massachusetts Birth 2006 Report, and you all have a copy of that report." Some excerpts from her presentation follow:

"I will begin today with an overview of births in Massachusetts, and compare them to those indicators in the United States. Then I will look at diversity in race and ethnicity, and the disparities in birth outcomes based upon race and ethnicity at geography and

socioeconomic indicators, and this year we have added gestational diabetes to the report."

- There were 77,670 births in 2006, which was an increase of 846 over 2005. On an average day, there are 213 births (some of them: 71 cesarean deliveries a day, four sets of twins, and 17 low birth weight infants).

Indicators for 2006 and how they have changed from 2000.

- The number of births has decreased five percent from 2000 (statistically significant – that is unlikely to have happened by chance alone).

- Teen births rates are down 18% (statistically significant). Smoking during pregnancy is down 24% since 2000. The percentage of low birth weight infants is up 11% and C-section deliveries have increased by 43% since 2000.

- The changes in infant mortality rates are not statistically significant. They are holding – stable. Massachusetts does very well in comparison with the United States as a whole. The teen birth rate is significantly lower. It is almost one-half the U.S. rate, and although the teen birth rate for the United States increased this year for the first time in 15 years, in Massachusetts, we remain stable. Preterm births (deliveries before 37 weeks of gestation is almost 30% lower than that of the United States.

- The infant mortality rate was lower than that of the United States, about 30%, and the C-section rate is significantly higher than that in the Unites States. In 2006, one-third of all births were delivered by C-section in Massachusetts. No statistics available on 2006 U.S. C-Sections.

- The infant mortality rate (number of infant deaths per one thousand live births in Massachusetts) looking at it from 1990 to 2006. In 1990, the infant mortality rate was seven deaths per one thousand live births. In 2006, it is 4.8 %. This is 30% lower than in 1990. From 1990 to 1996, the infant mortality rate declined significantly at about a rate of five percent per year, and that is annual percentage change (APC). Since 1996, the infant mortality rate has been stable. There have been non-significant changes.

- In 2006, for the second time in a row, less than 70% of births were to White Non-Hispanic mothers; and, of course, the drop in the percentage on Non-Hispanic, White Non-Hispanic mothers means an increase in other groups. For example, the percentage of Asians has almost doubled since 1990, and the percentage of Hispanics has increased by about one and half times. When we look at mother's ancestry or ethnicity, we see even greater diversity. We often find that there are greater differences in birth outcomes by ethnicity than by race.

In summary, Dr. West said, "There have been, over time, many successes in birth outcomes in Massachusetts. The birth outcome indicators compare very favorably with U.S. indicators, and you see that we have had decreasing and stabilizing rates in mortality

and teen births; but, of course, we have many challenges, including the increasing percentages of C-section deliveries, gestational diabetes, low birth weight and preterm infants, and Massachusetts must address the persistent disparities in birth outcomes by race, ethnicity, education and community. For example, the Black Non-Hispanic IMR is 2.6 times as high as that of the White Non-Hispanic Infant Mortality Rate, and you can see teen, the teen rate for Hispanics is six times that of White Non-Hispanics and others."

Dr. JudyAnn Bigby, Secretary, Executive Office of Health and Human Services, addressed the Council. She said, "I want to thank the Public Health Council. It has really been fabulous watching your work as you all have come together. We, the Governor and I, really appreciate how thoughtful you have been, and how interested, and how much of an advocate you are for advancing the public health of the Commonwealth, and we recognize that you have dealt with interesting and complex issues, and we look forward to continuing to hear what your thought are about it. Your work has really improved our ability to address many of these issues."

Dr. Bigby said further, "I am here today because this is an issue near and dear to my heart. It has been for more than 25 years. I am sad to say that we haven't solved the problems, but I wanted to make some comments about this most recent report. I have done a lot of work in Women's Health, and I want to state right up front, this is not an issue around babies. It is not an issue around infants. This is a Women's Health issue, and until we can understand the comprehensiveness of the problem, and the complexity related to how this problem relates to both the social standing of women and their health across their life span, not just when they are pregnant, I don't think we are going to continue to make the type of progress that we saw in that slide, looking at a hundred plus years of infant mortality, and we are still going to be at that tail end."

Dr. Bigby continued, "I wanted to take this opportunity to talk about a couple of things that impressed me about the most recent data report. First of all, I just want to comment on the continued increase in cesarean sections in Massachusetts. We know that this is a very important intervention for women who have high risk pregnancies, whose babies are at risk, and there is no doubt about that; but, as we see the trend continuing to increase both here and across the United States, I think it is important for us to really step back and say, why is this happening? Is this in the best interest of the health of the public and for the people who are involved? We know that C-sections have serious consequences to women, including postpartum infections, readmission to the hospital for uterine infections, and other complications, and for those of you who have not read this Sunday's Boston Globe Magazine, there is a very compelling story in there about a section that had grave consequences for a woman, and I am not one to make public policy by anecdote, so I am holding that out as a reason for us to be concerned, but I think it is important for people to understand that this is not a minor surgical procedure. It is a big deal."

Dr. Bigby continued further, "This year's report shows that cesarean section rates are continuing to increase in Massachusetts. I know that the reasons for that are likely to be very complex. I know that some of things that have been raised have to do with the

increasing age of women who are giving birth, questions about malpractice and the influence that it has on this, the rising rate of obesity among women; and so, there might be many different types of medical issues. However, I think we need to understand why this trend continues, and where it may plateau, and to make sure that we understand why the rates are increasing, and to make sure that we are doing everything we can, in Massachusetts, to make sure that the procedure is used in the most appropriate fashion."

In addition, Dr. Bigby said, "Via Commissioner Auerbach, I am asking the Betsy Lehman Center to convene a panel of experts in obstetrics, and ask them to focus on this question of C-sections in Massachusetts, and to come back with their analysis of why we see this trend, what we can expect over time, and whether there are things that we should be doing for the public's good in this area. I also want to comment on the increasing rate of Gestational Diabetes. As has already been said, this is an incredibly important issue because of the increased risk of complications during pregnancies, congenital defects and other issues. We also know that diabetes is increasing in the population in general, as obesity rates go up. We know that a lot of that is undiagnosed."

"One of the other interesting things in this data report", stated Dr. Bigby, "that was displayed here, is the percentage of women who are not getting adequate prenatal care, and if these woman are at risk for gestational diabetes, and they are not showing up until late in the game, we know that that does not bode well for the infants who are born. We need to better understand why this rate is going up, and do everything that we can to make sure that women who are at risk are getting care before they get pregnant, that they are planning their pregnancies, and that we are alert to this issue of gestational diabetes. I would like to see activities focused on that, and much of the work that we are planning to do in the realm of diabetes prevention and management at both the medical care level and the community level, will help us address this issue in some ways, I hope."

"Finally", she said, "I just want to mention and comment on the continuing disparities in infant mortality and other areas that we see in the Commonwealth. We are fortunate to see that the Black infant mortality rate has decreased to see that the Hispanic rate had decreased, but we have not done much to erase the gap between Black and White deaths, for example, and this has been true for decades. I really believe that this is a women's Health issue, and we have to do a much better job of making sure that women are healthy, that they are planning their pregnancies, that they are engaged in the health care system at the time that they become pregnant, but we are also learning more and more about the impact of community settings and the environment on all kinds of outcomes, including infant mortality and pregnancy outcomes. That is why it is so important for us to have a comprehensive agenda around eliminating disparities, and I know that Dr. Smith is going to talk about some of the initiatives that we want to do in the Patrick Administration. I want to point out that we are on the cusp of having, in Massachusetts, one of the only health care systems that will ensure that women can have access to care regardless of their reproductive status. Many of you know that too often in the past people, women in particular, got insurance based on whether they were pregnant, or whether they had little kids at home. We have moved away from that premise and that is a good thing for Massachusetts. In other programs in the Department of Public Health,

we are seeing a transformation of how women can be covered, and hopefully are accessing care in a more comprehensive way, and I hope to see that this will give us the ability to attack these disparities."

Dr. Lauren Smith, Medical Director, Department of Public Health, addressed the Council. She said, "…I want to acknowledge that at DPH, we are focused on targeted approaches that are really meant to uncouple the known risks from their adverse outcomes, and I just want to share with you a few examples of the kinds of activities that DPH is engaged in, to give you a sense of how we are approaching this. I want to pick up on a theme that Secretary Bigby mentioned, which is that, as an example, the infant mortality rates, although going down for all ethnic and racial groups, we continue to face an unacceptable gap in outcomes for African Americans versus White infants, and that tells us that whatever we are doing to decrease rates overall, although effective, needs to be challenged and thought about again in terms of reducing the gap, and that is one of the reasons why the Department is undergoing some additional data collection and two pieces of that, that will be important for our overall efforts are the PEL Program (Pregnancy to Early Life Longitudinal Data System) which links population-based data on births, deaths, hospital discharges, program utilization and outcomes, and this really is an incredible resource, and one that we are going to be relying on even more in the future, to help develop policies and programs that are meant to improve outcomes for all of our folks in the Commonwealth. The second source of data is PRAMS (Pregnancy Risk Assessment Monitoring System)."

Other DPH programs mentioned by Dr. Smith are: Diabetes and Prevention Program which has convened a multidisciplinary and interorganizational work group specifically to develop Massachusetts Gestational Diabetes Guidelines, and further to assist providers and organizations in implementing the guidelines to get the best outcomes for women who have been diagnosed with gestational diabetes and to diagnose it more often; partnering with local infant mortality reduction task forces in Boston, Worcester and Springfield; enhance outreach of the WIC program; in conjunction with the Tobacco Cessation Program, reduce smoking in women; and the Four Families Program, which is a home visiting program for homeless women and their families, in collaboration with another agency BTA.

In closing, Dr. Smith noted, "…We applaud the effect of all the hard work of providers and community organizations, as well as state and local agencies, we recognize that there is more to do, and we hope that that success will sustain the energy and the attention that is really required to tackle the additional difficult issues that face the Commonwealth's women and their children."

Discussion followed by the Council. Mr. Harold Cox inquired about infant mortality by race, income and education. "Do you see a different picture – especially for African American or Black births?" Dr. West replied, "We do not have a lot of socioeconomic information. We do have education…In the past, when we looked at African American mothers who are highly educated, that is to say, they should have the best performance and outcomes. We compared highly educated women and prepared them to the poorest

women in terms of socioeconomic status. We found that Black mothers still had the higher rate of infant mortality." Mr. Cox responded, by saying, "Is this suggesting that prenatal care is not the factor that impacts this?"

Secretary Bigby responded, "Prenatal care is absolutely important. Nobody is going to say that, because we haven't eliminated the gap in disparity, let's just throw out prenatal care. It is absolutely a necessity. I think that most people agree that prenatal care alone is not enough to address this issue. The issues that you raised about the interaction between race, education and other socioeconomic indicators is a good one, and it is why, in my statement I made, I pointed out that there is a complex array of issues that are probably related to this, and the issue around stress, and the physiologic component of that to prematurity, which is the leading cause of low birth weight babies and the leading cause of infant mortality among Black women, is a very complicated issue that has to do with cortisol, ACTH, and pituitary and adrenal glands, and the placenta, and all of that. And we are also beginning to learn that it is not just what happens to a woman at the time she is pregnant, it is before she is pregnant. It may actually have to do with what happened to her in utero, before she was even born, that predicts what is going to happen to her infant. So, this is not an easy thing to solve. It is not just a public health problem. We have to collaborate with our colleagues in Maternal/Fetal medicine and reproductive biology and other people who are interested in this, to understand it, but, you know, there are things that we can do to make sure that we are not just focused on the woman when she is pregnant, prenatal care. We know that that is not the silver bullet."

Dr. West noted for the record, that the prenatal care indicators that they use are based on the trimester that the prenatal care began. It is a combination of that and the number of visits. It is not addressing quality. It is just the timing and the initiation.

Council Member Dr. Michele David asked, "I was looking at the black curve and I was wondering, within that analysis, have you looked at the difference between native born and foreign Blacks to see if there is a difference or something that could be learned?" Dr. Bruce Cohen, Director, Division of Epidemiology, DPH answered, "Yes, we have. In the full report, you will see tables that look at detailed ethnicity. It has been our contention and we have done a lot of work looking within broad race groups; and, in fact, we had a special perinatal report that we would like to get back to, that we issued about six or seven years ago, that looked at differences among Blacks, looked at Haitians, American-born Blacks, African Blacks, Blacks from different parts of the world; and, as James indicated before, we see more variation among Blacks and among Hispanics than between broad race groups, and we are pushing new data collection standards for the Department that will collect this detailed ethnicity or ancestry data, so we can understand better how to target programs that are culturally appropriate, and that deal with linguistic and social isolation, as well. With respect to Haitians, some indicators are better than American-born Blacks, and some are worse. For instance, I think that the Gestational Diabetes rate among Haitians is higher than for African Americans but we are developing the ability to disaggregate, to really target our data better."

Dr. Barry Zuckerman, Council Member, mentioned opiate addiction of pregnant mothers. He said in part, "…I remember 15 years ago, we had significant focus on addicted women during pregnancy. That certainly has eroded over the subsequent fifteen years. I wonder what the status is, and I wonder if, again, this is another reason not to visit suboxone. It doesn't take care of social problems but sometimes, if there is a medicine like this is supposed to do, to prevent some of the adverse behaviors that are associated with the other treatments and, again, I just want to make that connection between the last presentation and this, and wonder whether we could look at data of addicted women and low birth weight babies, and to understand if some of that disproportionately is driving what we saw. Again, realizing I don't want to over simplify on any one group of any one behavior."

Dr. Lauren Smith, Medical Director, DPH, responded, "I think you bring up a very good point, that one needs to be aware of all the constellation of risk factors that might lead to adverse outcome pregnancy. However, I think if you look at overall incidents in absolute numbers of women who have substance abuse during pregnancy, and the 77,000 births that we have in the Commonwealth, although it is an intense and important problem, it is still a relatively small percentage and I don't think it is driving the bulk of the low birth weight and premature births."

Dr. Zuckerman inquired, "Do you know that empirically? In other words, if it is likely that most addictive woman, particularly to opiates, will have a low birth weight baby. Therefore, the question is, how many of them are there and what variances contribute to the overall problem?"

Secretary Bigby replied, "I don't know what the current data show. A couple of decades ago, when people were very concerned about this in a very public way, a lot of assumptions were made about who has a drug problem and who does not. Most of the data from the period showed that there was no difference in drug use between White women and Black women; and so, linking that to the disparity and the lack of achievement in closing the gap, I think is a little bit problematic. I also remember the type of behavior that providers adopted when people became concerned about this problem and disproportionately testing certain women based on their race, Supreme Court cases included. So, it is a good question, but before we introduce it as a mechanism for looking at this, I mean, I think women who are having problems with addiction need treatment regardless of their pregnancy status. If that is an opportunity to identify them, and get them into treatment, we want to make sure we do that in an environment that doesn't punish them for presenting, and those are very complicated issues."

No Vote/Information Only

FINAL REGULATION: REQUEST FOR FINAL PROMULGATION OF PROPOSED AMENDMENTS TO 105 CMR 130.000 (HOSPITAL LICENSURE) REGARDING PREVENTION AND REPORTING OF HEALTHCARE-ASSOCIATED INFECTIONS – Part 2 – Grant Carrow:

Dr. Grant Carrow, Deputy Director, accompanied by Dr. Paul Dreyer, Director, Bureau of Health Care Safety and Quality, presented the final proposed amendments to 105 CMR 130.000 to the Council. He said, "I am here before you today to ask for your approval of final promulgation of regulations to amend hospital licensure regulations to provide for a system of reporting of healthcare-associated infections."

Dr. Carrow noted the proposed amendments were a joint effort among two Bureaus and staff involved in the Department: Dr. Albert DiMaria, State Epidemiologist and Bureau Director of Communicable Disease Control, Ms. Nancy Ridley, Director, The Betsy Lehman Center for Patient Safety and Medical Error Reduction, Ms. Laurie Kunches, Senior Consultant and Project Manager for this project, of The Johnson Research and Training Institute. He noted further that the administrative and programmatic details of the program are not set forth in the hospital licensure regulation but will be set forth in an administrative guideline instead.

Dr. Carrow said in part, "…The regulation itself will require acute care hospitals to report certain healthcare-associated infection information to the Department and to the Betsy Lehman Center…Let's move on to the purposes of the HAI reporting system, and they include providing monitoring and surveyance by the Department of Public Health, providing information for future development of metrics and that will be mainly conducted by the Betsey Lehman Center. The reporting system is intended to provide more transparency in healthcare, and you had some discussion about that earlier today; and, finally, to provide feedback to the hospitals themselves, as they evaluate their prevention efforts in this area…Hospitals will report specific data that DPH specifies through the National Healthcare Safety Network system of the Centers for Disease Control and Prevention. This is a web-based system that the CDC maintains and that will participate in…Once hospitals report the data to that system, they will provide DPH and the Betsy Lehman Center access to designated data and reports as appropriate, and the regulation calls for all the registration and training on the NHSN to be completed late Spring so that the hospitals will be ready to start reporting on July 1, 2008…There are three levels of reporting. The first level will be reporting to DPH and reports on that data will be made available to the public so that data can be compared between hospitals. The second level is reporting certain data to the Betsy Lehman Center (data measures that are not well defined and variabilities between hospitals' data, therefore data not suitable for comparisons between hospitals). Staff will study this data to see if measures or definitions can be developed that will allow this data to be compared between hospitals. The third level will be data that hospitals will report on for their own use in developing and monitoring their prevention efforts."

Dr. Carrow noted further, "…We have an epidemiologist in the Department, who will be working on analyzing the data and preparing reports, including those for the public. We

will be convening a Technical Advisory Group, to convene in March, which will be comprised of experts and clinical leaders, professional organizations, consumer representatives to guide DPH on the implementation of the program, and establishing the guidelines. Basically, they are a successor to the Expert Panel. He noted that the Public Health Council asked for consumer representation in the Advisory Group Council when he was before them in November.

Dr. Carrow reiterated what Dr. Dreyer and Commissioner Auerbach said earlier about the development of a web site with the Health Care Quality and Cost Council to display the information and also will use other modes of communication such as materials in multiple languages, multiple literacy levels and be culturally sensitive and age appropriate.

Dr. Carrow noted that a public hearing was held on the proposed amendments on December 14, 2008 in which five individuals testified…He said, "The testimony was generally supportive of this effort. There were many excellent suggestions on administrative and programmatic matters that we will take under consideration, and most of which we agree with, and are consistent with the goals of this program. We will also bring all those suggestions before the Technical Advisory Group so they can also digest them and make their own assessments. We have made minor technical changes to the amendments we brought to you in November, to accommodate some of those issues raised in the testimony."

In closing, Dr. Carrow said, "The HAI reporting system will be based on the Expert Panel recommendations, as I reviewed with you. It will be evidence-based. It will be phased in so that we are collecting information that can be comparable between hospitals. We will also identify areas for performance and quality improvement of that through this system. That is one of the goals, as well as assessing the impact of prevention intervention on infection rates….I am requesting approval for final promulgation of these regulations."

Discussion followed by the Council. Dr. Meredith B. Rosenthal asked, "The Technical Advisory Group that you mentioned, do you envision that to have an ongoing role in maintaining the sub-regulatory matter? Dr. Carrow said in part, "…Yes, we will need to convene the Technical Advisory Group on an ongoing basis. I think we are doing it quarterly." Ms. Lucilia Prates Ramos noted, "I applaud the Department and all the work that went into this. It is the first step and we have come a long way."

Dr. Michael Wong made the motion to approve the proposed amendments to 105 CMR 130.000. After consideration, upon motion made and duly seconded, it was voted unanimously to approve **Final Promulgation of Proposed Amendments to 105 CMR 130.000 (Hospital Licensure Regulations) Regarding Prevention and Reporting of Healthcare-Associated Infections;** that a copy of the approved regulations be attached and made a part of this record as **Exhibit No. 14,896;** and that a copy be forwarded to the Secretary of the Commonwealth.

Chair Auerbach noted, **"**We are delighted that this has passed. We expect that it will prove to be very helpful in terms of improving the quality of care in Massachusetts."

PRESENTATION: "HIV AND AIDS: An Assessment of Service Gaps and Unmet Need":

Mr. Kevin Cranston, Director, Bureau of HIV and AIDS, DPH began the presentation, "Despite the high quality medical care and superb access to medications that exist in Massachusetts we, in the Department, have seen growing incidence of the increasing complexity of the lives and needs of individuals living with HIV and AIDS in Massachusetts. In order to fully understand those, however, we rely on AIDS service organizations, such as AIDS Action Committee of Massachusetts, and other community-based organizations, to better inform us about those needs, and to put those into a context of the lives that the people with HIV and AIDS are living, beyond struggling with HIV itself. These data that I am presenting are our own epidemiologic data. I am appreciative of the work of the HIV/AIDS Surveillance Program, and the Bureau of Communicable Disease Control, led by Dr. Alfred DeMaria, and these are for background and comparison to the demographics of the data that Ms. Haag will be presenting."

He continued, "To remind ourselves that, while a significant number of individuals living with HIV and AIDS are not heavy utilizers of our service system, that approximately a third of individuals living with HIV and AIDS are being seen in our non-medical support services, funded by the Department of Public Health."

Mr. Cranston said further, "If I may give a brief summary of where we stand in terms of the epidemic, our most complete year of data that we feel can reliably indicate current incidence of disease, of HIV disease in Massachusetts, is 2005, with eight hundred and eighty-five cases having been reported de novo in 2005. These include some individuals where their AIDS diagnosis was the first indication of their HIV infection, and that still unfortunately represents about 28% of all new diagnoses. Persons living with HIV and AIDS have passed the 17,000 mark in Massachusetts and continue to grow, and this is out of over 29,000 cumulative cases of HIV and AIDS that have been diagnosed since the beginning of the epidemic in the early eighties. This is significantly a non-White pattern of infection in Massachusetts, with over 50% of cases, in people living with HIV and AIDS, being Black Non-Hispanic, Hispanic, Asian Pacific Islander, and other populations, with a small percentage where no race or ethnicity is identified, and it still is substantially an epidemic of men, but this is a shifting pattern, with the proportion of cases amongst women, particularly living cases, continuing to increase."

"Because of our success in providing high quality medical care and medication access", he said, "survival continues to improve amongst people living with HIV and AIDS; but, as we have a near steady state rate of new infection, around nine hundred new cases per year, we continue to see an extraordinarily steady increase in the prevalence of HIV, in the number of people living with HIV. It represents a nearly six percent increase in the number of living cases on an annual basis."

Mr. Cranston stated in closing, "The impact of HIV and AIDS on communities of color is grossly disproportionate to their numbers in the population, with only about six percent of the Massachusetts population being African American or other Black residents, another six percent being Latino or Hispanic. When examined on a case rate basis, Black individuals being 11 times more likely to be living with HIV or AIDS than White residents of the Commonwealth and Hispanic residents being approximately nine times more likely to be living with HIV and AIDS. We are seeing an aging of the epidemic. This is partially a good news story in that people have had the opportunity, though diagnosed more likely in the age group of thirty to forty-four, we are seeing a full twenty-six percent of individuals currently, at least that is on December 31st of 2005, being 50 or older, and approaching fifty percent of people living with HIV and AIDS on that date, being forty-five or older."

Ms. Rebecca Haag, Executive Director, AIDS Action Committee of Massachusetts, R.I. Hotline, and the Executive Director, AIDS Action Council, Washington, D.C. addressed the Council, "…As the Commissioner indicated, I not only manage the AIDS Action Committee here in Massachusetts, we serve about 2800 clients a year, both here in Massachusetts, and we also run a hotline for Rhode Island. We do public policy work, not only here in Massachusetts, but somewhat regionally, and I also have the privilege of serving as Executive Director of the AIDS Action Council in Washington, DC, where we do advocacy work at the federal and public policy level. I would just like to, first of all, acknowledge that you have many people right here on the Council, including Michael Wong, who is the Chairman of the Board of the AIDS Action Committee, and Harold Cox, who I can assure you is not confused about this issue in any way, has been a long time advocate for HIV and AIDS, as has the Commissioner…"

She said further, "On a national level, to put a context on this…1.2 million people across the country are living with HIV and AIDS, that the CDC, for the last ten years, has reported 40,000 new infections, and the hope that that has sort of been a steady state, although I would question whether 40,000 is an acceptable rate in the richest country in the world. The CDC will, in the next four to six months, revise those figures and be reporting that it probably has been closer to 55,000 or 60,000. This epidemic has been raging on, not only in the nation, but in Massachusetts, for over 25 years. I applaud the Department and our health care system here for having given us many advantages to care for people, but I would argue that we are a long way from winning this battle, and what we are presenting today is what we have heard from people seeking care here in Massachusetts. I would encourage, as a Public Health Council, to actually invite people living with HIV/AIDS in for a presentation to really tell you what they are facing in terms of barriers in the system. I will try to summarize and be their voice today, but probably can't do it nearly as well as they would, if they were here."

Ms. Haag continued, "…We ran a lot of focus groups, just trying to get at what the key issues were. Those happened last summer. We conducted a survey, in many cases, on site, at AIDS service organizations all across the state. As you see here, we distributed over a thousand of those surveys and got about a 20% response rate. These surveys were extensive long surveys. Clearly, there was a desire to have their voices heard. They

spent the time to do that. Who were these people that responded to this? This mirrors pretty clearly the data that you just heard from Kevin. We are probably a little over-represented in terms of people of Color, but these are people seeking care in the system. They still are heavily male, and disproportionately People of Color, and I would point out that they really are, this is an aging population, that has now been on incredibly complicated drug regimes for, in some cases, ten, fifteen years; and, as they age, they are facing many complicated issues. This is sort of an indication of what the co-morbidities are. I just point out to you that Hepatitis C, even though it is second to depression, is probably the leading, in terms of the cause of death for people still living with HIV/AIDS, that's the key issue. Having HIV and having Hepatitis C, which compromises the liver, I don't need to tell all of you, is a disaster for people trying to fight this deadly infection; but also, as you see, you see complications from depression, anxiety, substance abuse, and these folks are really, in many cases, seeking services for many things beyond their HIV and AIDS. People who present to us, often in crisis, HIV and AIDS is sometimes number three on their list of issues. We are dealing with the most difficult cases. These folks are primarily poor. These are folks asking for care. There are many people in the Commonwealth living with HIV and AIDS, who might have some financial resources, might have private insurance, but these are the people coming to us under the purview of the Department of Public Health, and other federal sources, looking for care. Only about 10% of those people have any earned income…basically they are counting on public funding for survival."

Additional survey respondents' statistics from Ms. Haag follow:

- 28% of them were hospitalized two or more times over the last several years
- 35% of them seeking housing three or more times had been hospitalized two or more times
- 25% of the respondents have been incarcerated, overall; 13%, two or more times in the last two years, and 14% had been incarcerated for two years or more. (Due to incarceration, many face barriers to getting employment and housing)
- 30% are in unstable housing situations
- 20% were in residential programs seeking substance abuse services or some other kind of treatment
- 44% have transportation issues (bureaucracy requirements?)
- 40% sought substance abuse treatment in the last two years
- 66% sought mental health services

Ms. Haag posed a question, "Is it the chicken or the egg argument? Is the unstable housing also leading to the fact that they are getting sicker? Are they also seeking hospitalization as a way to find care and treatment and get out of the elements?"

"I would point out here that probably one of the issues mostly driving hospitalizations is the co-morbidity rates. If someone has HIV and AIDS, and heart disease, seventy-five percent of those people actually were hospitalized two or more times. As you see, it is the other complicated issues, particularly those issues many of us face as we age, are the things that are driving people to additional hospitalization."

"If our system is trying to habilitate people and we simply put them back on the streets, they lose their health care coverage and with barriers to housing, and employment, they are not making much progress, often they are reincarcerated," noted Ms. Haag.

Ms. Haag said further, "…In public health, housing is health care, that people who are in stable housing can stay on very complicated medical treatments; they tend to have more stability in their lives. Thirty percent or one-third of these people have been seeking housing three or more times. Fifty-six percent needed housing in the last two years (incarceration and CORIs are a major barrier)".

Ms Haag noted, "Inadequate nutrition and I don't want to seem to be complaining, the good news is that people with HIV and AIDS actually have better access to many of these things than other folks do in the state, but it is critical, when you are on this drug regime, that you have adequate nutrition, that going to a food bank and just getting any old kind of food, won't help you with the disease management. We try to provide protein enriched programs. We try to accommodate people who have diabetes, who have high blood pressure, but clearly, there is not enough and many of them continue to be afforded a lack of that."

Ms. Haag noted further, "There is a barrier to self-sufficiency. Ten percent are working. Thirteen percent are working part-time, but the big battle here, is if you work too many hours and make too much money, you begin to lose your benefits and it is too critical to these people that they have health care coverage…"

In conclusion, Ms. Haag noted, "Clearly, there are major barriers, as we talked about. I would remind you that there are still five to seven thousand people living in the Commonwealth who are not in care, who may not know their status; and, again, remind you that this is infectious. If they are not on drugs, and they are continuing to engage in risky behaviors, they can spread the disease. People living with HIV and AIDS have some very specific needs related to that, but have a lot of horizontal needs….HIV and AIDS is an infectious disease. We know what causes it. We know how it is transmitted and, yet, we haven't stopped it. HIV and AIDS is the Perfect Storm of health care disparities. Fifty percent of new infections in the State are People of Color, who represent thirteen percent of the population. It is the number one cause of death, nationally. I don't know if this is true in Massachusetts. Number one cause of death for African American women, ages 25 to 34. Young Black men in our City are estimated to be infected with HIV at thirty-five and forty percent rates. There is still discrimination and stigma. A doctor recently at MGH told us a story about a young woman, who is now her patient for the last five years, an African American Woman, living in the South, moved to Boston when she found out she was HIV positive so that no one would find out. This is a professional woman with a job. She has not told her family. She has not told her friends, and she has not made any friends here for fear of the stigma of someone knowing she is HIV positive. This is somebody with resources. Imagine if you have a substance abuse issue. Imagine if you are in an abusive relationship. Imagine if you are a young woman who stays with somebody who may have infected them because it is

your only source of income, and faced with that level of discrimination and stigma. The needs of people with HIV, as we talked about, are more complicated and we still don't have people in care. So, why am I here today? I am here today to call you to action. I am here today to ask you to solve the problem, not just address the problem. We have had the same programs, the same services, the same messaging, and it is not working. I think 900 new infections, although I applaud what we have done in prevention, and we have lowered that, is still unacceptable."

Her closing remarks continued, "Secretary Bigby, when she was here, said you are advocates. The Governor and I need your recommendation. So, I am asking that we apply the gold standard that Mr. Auerbach spoke about earlier. You were appointed by a Governor who said, together we can, and together we are not. I would urge you to think about what the plan should be. I would urge you to have a State plan. I am now involved in an effort to ask our next President to develop a National AIDS Plan. These plans need to have measurable outcomes. They need to have assigned responsibilities. They need to be across agencies in State government. They need to engage the business sector, the health care sector and the non-profit sector. There needs to be timelines, and there needs to be accountability, and there needs to be a financing plan. We have lost significant State dollars for HIV and AIDS over the years in this State. We have virtually wiped out comprehensive sex education in our schools. We need culturally competent prevention programs and, I think, only with an articulated plan with set outcomes can we reengage the broad public in what we really need to do to actually put an end to this epidemic. It shouldn't be passed on to the next generation; and, as an advocate in the community, representing many advocates and today serving as a voice to those living with HIV and AIDS, I urge you to use your leadership as a Council to join with us, to call for a National and State AIDS plan…"

Chair Auerbach responded, "…Thank you for that excellent presentation about where we are and for reminding us that this is not an epidemic that is over, but that we are in the midst of it, and that we need to make sure we have adequate resources, and appropriate plans, and attention to the issue. And your call around developing a State plan, I think is one that we want, will be addressing as a Council, and discussing, along with your other recommendations. I think today, simply because of the lateness of the hour and the fact that many of the Council Members have to go soon, I think we probably won't be able to have a fuller discussion, but we will take very seriously your presentation and the epidemiological information that Mr. Cranston presented. We will return to this issue and invite you back for that fuller discussion."

Ms. Haag, stated, "And I will bring folks who are living with the disease with me." Chair Auerbach replied, "I think that would be very appropriate."

No Vote/Information Only

New Business: Awards to Senator Richard Moore and State Representative Peter Koutoujian:

Chair John Auerbach, Commissioner, Department of Public Health presented awards to Senator Moore and State Representative Peter Koutoujian and he said, "…We passed, earlier this morning, a regulation which was a regulation to require, for the first time, the public reporting of Hospital-Acquired Infections, and we also spoke about the issue of making reportable and transparent to the public, information about serious adverse incidents that occur in hospitals, and the need for that also to be a priority, and the Department talked about what it would do with the Council Members in order to gather that information. We, in terms of taking those action steps, the Council today wanted to formally acknowledge the legislative leaders that have really paved the way in terms of these issues. We are so lucky to have, in the Commonwealth, legislative leaders who have been bold and outspoken about the importance of taking aggressive action to ensure that patients receive high quality care and I can say, really without reservation, the Department would not have taken the action, and the Council would not have taken the action it has taken, had it not been for the leadership of these two individuals. We are honored today to have them here. I am going to introduce each of them, and award them a recognition of the appreciation of the Council and the Department for their leadership, and ask if they would like to join us at the podium and have any comments with regard to that….First, I would like to present the Recognition Award to Senator Richard Moore, and the Award says, The Department of Public Health and the Massachusetts Public Health Council would like to recognize you for your bold and effective leadership in reducing Healthcare-Acquired Infections, and I would also add, for your bold and effective leadership in addressing a wide range of different leading health and health care issues Senator Moore, thank you."

Chair Auerbach recognized State Representative Peter Koutoujian: "I would like to recognize and ask you to come forward, State Representative Peter Koutoujian. I would like to recognize you for your bold and effective leadership in addressing Healthcare-Acquired Infections and, as I was saying to Senator Moore, thank you for your leadership on so many different Public Health issues. We really appreciate so much your guidance and assistance."

Senator Richard T. Moore, Uxbridge, Chair, Joint Committee on Health Care Finance stated, "I think in the Legislature, they consider me the bold one and he is the outspoken one; and as I have said before, I have been Chair of the Health Care Committee since 1999, and I was as tall as Peter when I started….I think the area of infection control is one that we are concerned about at the State House, and I think throughout the Commonwealth, on the issue of containing the cost of health care and improving the quality, and this is an area where I think we can make significant advances in both areas, both improving quality and containing cost, if we can prevent infections."

Senator Moore continued, "I have often spoken of the Centers for Disease Control reports talking about forty percent of physicians and nurses who don't always routinely wash

their hands, and now we have had a recent study that even that isn't totally effective if you don't go under the fingernails and remove rings, and a few other things. We are really learning, I think, nationally as well as here, and I am very pleased that the Council has moved forward with this initiative. I think it is one that we can't just announce it and leave it. It is one that is going to require, I think, continued guidance and oversight, and I am sure we will be encouraging the Department, both financially, as well as statutorily, to strengthen and continue this effort, not only in the hospitals, but into the doctor's office, I think as well, and throughout the health system, where we need to address it, and everybody needs to have it as a priority. I think the Council is going in the right direction and we are certainly pleased to provide that level of support. I would say that, while the House and Senate don't always agree on a lot of things, this is an area, I think, we have got pretty strong agreement in both branches, and we are pleased that the Patrick/Murray Administration is joining us in this. It has been a long time coming, but I think one that is going to make a major difference in the lives of the people of the Commonwealth."

State Representative Peter J. Koutoujian, Chair, Joint Committee on Public Health spoke next, "It is really nice to be back with Senator Moore. Since they split our committee, we don't get a chance to share the stage as much anymore. This is a really important issue. While Senator Moore was working on Healthcare Reform through his Healthcare Finance Committee just about two years ago, a colleague of mine from the House came and said, you know, I just lost a brother-in-law to what I believe was a Hospital-Acquired Infection; and so, we held a hearing. Now, when the Commissioner and I spoke at the Campaign to Strike Out Infections with Terry Francona recently, who almost died from a Hospital-Acquired Infection, and we spoke about not just hospital, but Community-Acquired Infections, I started to think back to the first hearing, the one we held based on my colleague's experience. We held it in Peabody, and my staff gave me the date, and they said it was sometime in September/October of 2006, and it seemed like that couldn't have been the date. It must have been in 2005 or 2004. It couldn't have been less than a year and a half prior to this event because it seemed like so long ago, and we traveled so far on this issue, and yet, it seems like we have so far still to go."

Representative Koutoujian continued, "As we keep catching up with these germs, so to speak, they continue to progress, and I think that we are making great strides. This Council's work and it is great to see, be here before the new and approved and amazing Council. This Council's work and the Department's work, and I think the work of the Senator and my Committee, will make a difference in saving lives, and I personally note, two of my colleagues who have had someone die as a result of this, or are still in Intensive Care as a result of this, some months later; a very good friend of mine, also the same thing, barely was in full septic shock. It is amazing, when you mention this issue, and I was in court this morning, mentioning that I was going to be recognized for this, that's why I had to leave court quickly, and at least two people came up and said, you know, I know someone, or a family member of mine, or a friend of mine, had to endure something like this. This is something that has reached so far into our community, into our society; and yet we are just catching up with it now. This work that we do today, that you do, that the Department does, will be critical in saving health care dollars, tremendously important to save because we can do much more with them, but really

saving lives and saving the suffering that so many individuals and their families go through every day because of something so preventable, something so simple, that we have really got to strive to be better at this, and with these steps that this Council is making today, the Department is making, and I think Senator Moore's work, and the work of my Committee, I think we are making great strides, and hopefully, we will be able to get to the point where we are feeling we are ahead of the game. That will be a great day, when we feel, when we are that point. Thank you very much."

Senator Moore further noted and Representative Koutoujian agreed about the need for physicians to limit prescriptions for antibiotics. Senator Moore said in part, "…I think we need to look at, work probably with the Medical Society, the hospitals and others to begin to educate the population that antibiotics don't cure everything, the germs build up resistance and we have to keep finding stronger medication which sometimes has side effects that we don't want to see…" Representative Koutoujian added in part, "…If we can do it with cough syrup, these declarations that syrup doesn't save everyone and in fact, it might harm…If we can get people and parents to understand that cough syrup isn't the end-all/be-all to saving their children from suffering through the night, or themselves, we can do it with the antibiotics. I think that the doctors do need sort of the authority behind that, from a higher authority, whether it is the State, whether it is the societies, whether it is on a national level to say, we need to stop doing this and not have to feel the wrath of concern and questions of their patients, which they are understandably concerned about."

Chair Auerbach stated, "This is a reminder about why you both are such remarkable leaders, that in terms of coming today and accepting our thanks, you are also providing us with a new challenge, which is to look more deeply into this issue, the issue of over prescription of antibiotics. I think we will accept that as a challenge and try to come up with efforts that we can do, in partnership with you going forward and on behalf of the Council Members and the Department, thank you for your leadership and guidance."

The meeting adjourned at 11:30 a.m.

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John Auerbach, Chair

LMH